



MIAMI-DADE COUNTY



Group No: 06756

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**This Certificate Contains a
Deductible Provision.**

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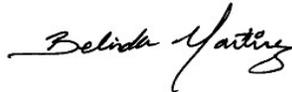
DELTA DENTAL INSURANCE COMPANY

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DENTAL CERTIFICATE OF COVERAGE

Delta Dental PPOSM Program

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental Insurance Company ("Delta Dental") and cannot modify the Contract in any way.



**Belinda Martinez
President**

GROUP HIGHLIGHTS

PLAN:

You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:	Standard Plan		Enhanced Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic & Preventive Benefits:	100%	100%	100%	100%
Basic Benefits:	75%	75%	75%	75%
Restorative Benefits:	100%	75%	100%	75%
Major Benefits:	50%	50%	50%	50%
Orthodontic Benefits:	Not Covered		50%	50%
DEDUCTIBLES:				
Per Enrollee each Calendar Year:	\$50		\$50	
Per Family per Calendar Year:	\$150		\$150	
Lifetime for Orthodontic for each Enrollee:	Not Covered		\$50	
The deductible does not apply to Diagnostic and Preventive Benefits.				
PLAN MAXIMUM AMOUNT:				
Per Enrollee per Calendar Year:	\$1,000		\$1,500	
Lifetime for Orthodontic Services for each Enrollee:	Not Covered		\$1,000	

Takeover Deductible Credit: Any lifetime deductible you satisfied for Orthodontic Benefits under the Contractholder's prior plan will be credited towards the lifetime deductible under the Contract.

Lifetime Takeover Credit:

Delta Dental will receive credit for any amounts paid under the Contractholder's previous dental care contract, if applicable, for Orthodontic Benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

PREMIUMS:

You may be required to contribute towards the cost of your coverage and towards the cost of your Dependent's coverage. See your Departmental Personnel Representative (DPR) for complete information.

Delta Dental may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

DEFINITIONS

Terms when capitalized in your certificate of coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Approved Amount -- the maximum amount a Dentist may charge for a Single Procedure.

Benefits (In-Network or Out-of-Network) -- the amounts that Delta Dental will pay for dental services under this Contract. In-Network Benefits are those covered by this Contract and performed by a Delta Dental PPO Dentist. Out-of-Network Benefits are those covered by this Contract but performed by a Delta Dental Premier® Dentist or Non-Network Dentist.

Claim Form -- the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

Contract -- the written agreement under which Benefits are provided.

Contract Allowance -- the maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

- by Delta Dental PPO Dentists is the least of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee or the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement;
- by Delta Dental Premier Dentists (who are not Delta Dental PPO Dentists) is the least of the Dentist's submitted fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

Contractholder -- the employer contracting to obtain Benefits.

Delta Dental PPO Dentist (PPO Dentist) -- a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO fees as payment in full and comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

Delta Dental PPO Dentist's Fee (PPO Dentist's Fee) -- the fee for each Single Procedure that PPO Dentists have contractually agreed to accept as payment in full for treating PPO Enrollees.

Delta Dental Premier Dentist (Premier Dentist) -- a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

Dentist -- a person licensed to practice dentistry when and where services are performed.

Dependent Enrollee -- a dependent of a Primary Enrollee or domestic partner who is eligible for Benefits under the Contract.

Effective Date -- the date the program starts. This date is given on the booklet cover.

Enrollee -- a Primary Enrollee or Dependent Enrollee enrolled to receive Benefits.

Maximum Plan Allowance (MPA) -- the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of network Dentist.

Non-Delta Dental Dentist -- a Dentist who is neither a Premier nor a PPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period -- the time of the year during which employees may change coverage for the next Contract Year.

Participating Dentist Agreement -- an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

Participating PPO Dentist Agreement (PPO Dentist Agreement) -- an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a Delta Dental PPO program.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee -- any employee or retiree eligible for Benefits under the Contract.

Procedure Code -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

Qualifying Status Change -- a change in:

- a) legal marital status (marriage, divorce, legal separation, annulment or death);
- b) number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- c) employment status (change in employment status of Enrollee, spouse or dependent child);
- d) dependent child ceases to satisfy eligibility requirements (limiting age or student status);
- e) residence (Enrollee, dependent spouse or child moves);
- f) a court order requiring dependent coverage;
- g) domestic partners and child(ren) of domestic partners; or
- h) any other current or future election changes permitted by IRC Section 125.

Single Procedure -- a dental procedure that is assigned a separate CDT number.

CHOICE OF DENTIST

Enrollees may choose a Dentist from Delta Dental's panel of PPO Dentists and Premier Dentists, or Enrollees may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at www.deltadentalins.com/mdc. Enrollees are responsible for verifying whether the selected Dentist is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, Enrollees should always confirm with the Dentist's office that a listed Dentist is still a participating PPO Dentist or Premier Dentist.

PPO Dentist

The PPO program potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Dentists will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentist

The Premier Dentist, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

Non-Delta Dental Dentist

If a Dentist is a Non-Delta Dental Dentist, the amount charged to Enrollees may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the MPA and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the Dentist's submitted charge.

Additional advantages of using a PPO Dentist or Premier Dentist

- a) The PPO Dentist and Premier Dentist must accept assignment of Benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- b) The PPO Dentist and Premier Dentist will complete the dental Claim Form and submit it to Delta Dental for reimbursement.

WHO IS ELIGIBLE?

Eligibility for Enrollment

The Contractholder shall provide eligibility for coverage to any full-time County employee who has completed 90 days of employment. Any part-time employee who consistently works at least 60 hours bi-weekly and has completed 90 continuous days of active employment is also eligible. Coverage is effective the first day of the month following, or coincident to 90 days of employment. There is a 30 day grace period to enroll for benefits. Executives, as determined by the County, are eligible for first day coverage.

Retired employees are eligible for coverage as defined by the Contractholder's policy.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- a) Lawful spouse or domestic partner (unless also an eligible County employee) named in Contractholder's Affidavit for Domestic Partnership;
- b) Unmarried dependent children from birth to the end of the Calendar Year of their 26th birthday if:
 - (1) the child is dependent on the Eligible Person/Primary Enrollee for support; and
 - (2) the child lives in the Enrollee's household; or
 - (3) the child is a full-time or part-time student.

Children include natural children, step-children, adopted children, foster children, children of your domestic partner, custodial children and newborn children including a newborn child of a covered dependent child.

Newborn children, including a newborn child of a covered dependent child or a newborn child where a written agreement to adopt has been entered into prior to birth, are eligible from the moment of birth. Adopted children, foster children and custodial children are eligible from the moment of placement in the Enrollee's residence. Notice of birth, adoption placement, foster home placement or other custodial placement of a child with Enrollee must be received within 31 days of the birth or placement. If notice of birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of the birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement. Eligibility for a newborn child of covered dependent child terminates 18 months after the birth of the newborn.

- c) A child 26 years or older may continue to be eligible as a dependent if the child is not self-supporting because of physical disability or mental incapacity that began before age 26 and the child is mostly dependent on the Eligible Employee for support and maintenance. Proof of these facts must be given to Delta Dental or to the Contractholder within 31 days if it is requested and will be kept on file. Proof will not be required more than once a year after the child is 27.

Enrollment Requirements

If you are paying all or a portion of premiums for yourself or your dependents then:

- a) You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.
- b) All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period. If notice of a birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of a birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement.
- c) You must pay Premiums in the manner elected by the Contractholder and approved by Delta Dental. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- d) If you pay Premiums for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental until your dependents are no longer eligible or until you choose to drop dependent coverage, coverage may not be changed at any time other than during an Open Enrollment Period or within 45 days of a Qualifying Status Change.
- e) A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Loss of Eligibility

Your coverage ends the earlier of on the last day of the pay period you stop working for the Contractholder provided premiums are paid, or immediately when the Contract ends. Your dependents' coverage ends when your coverage ends or on the date when dependent status is lost.

The limiting age for unmarried dependent children is the end of the calendar year in which the child reaches age 26. Coverage may be extended to the end of the calendar year in which the child reaches age 26 if a) the child is dependent on the employee for support and b) is living in the employee's household OR is a full time or part-time student.

Termination of Benefits on Voluntary Loss of Eligibility

Delta Dental will not pay for Benefits for any services received after your coverage ends. However, Delta Dental will pay for a Single Procedure incurred when you were covered if such procedure is completed within 90 days of the Enrollee's voluntary termination of coverage. A dental service is incurred as follows:

- a) for an appliance (or change to an appliance), at the time the impression is made;
- b) for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- c) for root canal therapy, at the time the pulp chamber is opened; and
- d) for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

Except for an employee absent from work due to a leave of absence approved by the Contractholder or governed by the "Family & Medical Leave Act of 1993, you and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence.

Benefits for you and your Dependent Enrollees will resume as follows:

- a) if coverage is reactivated in the same Calendar Year, deductibles and maximums will resume as if you were never gone; or
- b) if coverage is reactivated in a different Calendar Year, new deductibles and maximums will apply.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

If you are rehired within the same Calendar Year, deductibles and maximums will resume as if you were never gone.

Continued Coverage Under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date you fail to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under (COBRA)

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for employees and their Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. See your Departmental Personnel Representative for complete information.

DEDUCTIBLE

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible, but you do not pay a deductible for Diagnostic and Preventive Benefits.

MAXIMUM AMOUNT

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the Enrollee loses coverage, if treatment is stopped, or if the Contract with your employer is canceled.

BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental will pay the Benefits for the types of dental services as described below. Delta Dental will pay Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside the state of Florida, the Dentist will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under the Contract. Even if the Dentist bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Enrollee Coinsurance

Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights. You are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees reduced by the amount of such fees that is discounted, waived or rebated.

BENEFITS

Delta Dental will pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for covered services.

Diagnostic and Preventive Benefits:

- **Diagnostic:** procedures to assist the Dentist in choosing required dental treatment.
- **Preventive:** prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Basic Benefit) for payment purposes), topical application of fluoride solutions, space maintainers and cephalometric film.
- **Sealants:** topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- **Palliative:** treatment to relieve pain.

Basic Benefits:

- **Oral Surgery:** extractions and other surgical procedures (including pre-and post-operative care).
- **General Anesthesia or IV Sedation:** when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- **Endodontics:** treatment of the tooth pulp.
- **Periodontics:** treatment of gums and bones supporting teeth; periodontal maintenance.
- **Denture Repairs:** repair to partial or complete dentures including rebase procedures and relining.

- Other Basic Benefits: injection of antibiotic drugs, crown (inlay/onlay) repair, bridge repair, recement bridge, temporary crowns and adjustment of TMJ appliances.

Restorative Benefits:

Amalgam, synthetic porcelain, plastic restorations (fillings), composite restoration fillings for posterior teeth and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

Major Benefits:

- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.
- Other Major Benefits: tooth addition to existing partial denture; TMJ appliances.

Orthodontic Benefits: *(Additional Benefits available for Enrollees in the Enhanced Plan)*

Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions; transseptal fibertomy.

Note on additional benefits during pregnancy - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant or additional periodontal maintenance

procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

LIMITATIONS

Limitations on Diagnostic and Preventive Benefits:

- a) Delta Dental will pay for routine oral examinations and routine cleanings no more than twice in any Calendar Year (other than additional benefits due to pregnancy) while the person is an Enrollee under any Delta Dental program or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- b) A complete intraoral series and panoramic film will be provided by the same Dentist when required, but Delta Dental will only pay for these services once every three (3) years under any Delta Dental program.
- c) Bitewing x-rays are provided twice in any Calendar Year for each Enrollee.
- d) Topical application of fluoride solutions is limited to twice in any Calendar Year for Enrollees under age 19.
- e) Space maintainers are limited to the initial appliance only and to Enrollees under age 19.
- f) Sealants are limited as follows:
 - (1) to permanent molars to age 16 if they are without cavities or restorations on the occlusal surface.
 - (2) do not include repair or replacement of a sealant on any tooth within two (2) years of its application.

Limitations on Basic Benefits:

- a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.
- b) Denture relines and rebase are limited to once every three (3) years for each Enrollee.
- c) Periodontal cleanings will be provided only when the periodontal maintenance is medically necessary when and required by the Dentist.

Limitations on Restorative Benefits:

Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.

Limitations on Major Benefits:

- a) Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
- b) Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- c) Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e. the implant supported crown or denture.

Limitations on Orthodontic Benefits:

- a) Payment for orthodontics is provided monthly.
- b) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- c) Benefits end with the next payment due after loss of coverage. Benefits end immediately if treatment stops or if the Contract is terminated, whichever occurs first.
- d) Benefits are not paid to repair or replace any Orthodontic appliance furnished, in whole or in part, under this program.
- e) X-rays or extractions are not subject to the Orthodontic maximum.
- f) Surgical procedures are not subject to the Orthodontic maximum.

Limitations on All Benefits - Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a) a crown where a filling would restore the tooth;
- b) a precision denture/partial where a standard denture/partial could be used; or
- c) an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

EXCLUSIONS

Delta Dental does not pay Benefits for:

- a) treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- b) cosmetic surgery or dentistry for purely cosmetic reasons.
- c) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity.
- d) treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment.

- e) any Single Procedure started prior to the date the Enrollee became covered for such services under this program.
- f) prescribed drugs, medication, pain killers or experimental procedures.
- g) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- i) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- k) charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.
- l) services or supplies covered by any other health plan of the Contractholder.
- m) treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- n) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section, if applicable.
- o) services for any disturbances of the temporomandibular (jaw) joints.
- p) services for silicates.

EXTENSION OF BENEFITS

If your coverage under the Contract terminates, an extension of benefits in the form of reimbursed expenses will apply if:

- a) the dental services were recommended in writing and begun while the policy was in effect by the Dentist to you while you were covered by the Contract.
- b) the dental services were procedures for other than routine examinations, prophylaxis, x-rays, sealants or orthodontic services.
- c) the dental services were performed within 90 days after your coverage ceased under the policy or Contract and the termination of coverage did not occur as a result of your voluntary termination of coverage.

The extension of benefits terminates upon the earlier of:

- the 90 day period specified in the above third bullet item or
- the date you become covered under a succeeding policy.

If coverage or services for the dental procedures referred to in the above first bullet item are excluded by the succeeding contract through the use of an elimination period or limitation, you are not covered by the succeeding contract and the extension of benefits does not terminate.

All contractual limitations, exclusions or reductions that would have applied to the specific dental services had your coverage not terminated apply during the extension of benefits.

COORDINATION OF BENEFITS

Delta Dental coordinates the Benefits under this program with your Benefits under any other group prepaid program or Benefit plan including another Delta Dental plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Dentist's fees for the covered services. If this is the "primary" program, Delta Dental will not reduce Benefits, but if the other program is the primary one, Delta Dental will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under the Contract (see Benefits and Limitations).

- *How does Delta Dental determine which Plan is the “primary” program?*
 - (1) If the other Plan is not primarily a dental plan, this Plan is primary.
 - (2) If the other Plan is a dental program, the following rules are applied:
 - a) the Plan covering the Enrollee as an employee is primary over a Plan covering the Enrollee as a dependent.
 - b) the Plan covering the Enrollee as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - i) secondary to the Plan covering the insured person as a dependent and
 - ii) primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee),
 then the benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
 - (3) Except as stated below, when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
 - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
 - b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
 - c) However, if the other Plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- d) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the Plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).

- (4) The benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (5) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following will be the order of benefit determination:
 - a) First, the benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
 - b) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (6) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the Plan which covered that insured person for the shorter term.

AUTOMATED INFORMATION LINE

You may access Delta Dental's automated information line on a regular business day to obtain Enrollee eligibility and Benefits, group Benefit or claim status information or to speak to a Customer Service Representative for assistance. **(800) 471-1334**

CLAIMS

Claims for Benefits must be filed on a standard Claim Form which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(800) 471-1334
www.deltadentalins.com/mdc

PRE-TREATMENT ESTIMATE

A Dentist may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will predetermine the amount of Benefits payable under the Contract for the listed services. Benefits will be processed according to the terms of the Contract when the treatment is performed. Pre-Treatment Estimates are recommended for services \$300 or more and are valid for 60 days, or until an earlier occurrence of any one of the following events:

- a) the date the Contract terminates;
- b) the date the Enrollee's coverage ends; or
- c) the date the PPO Dentist's or Premier Dentist's agreement with Delta Dental ends.

CLAIMS APPEAL

Delta Dental will notify the Primary Enrollee if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reasons why the denial was wrong. The Enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

Delta Dental will make a full and fair review within 15 days after Delta Dental receives the request for appeal. Delta Dental may ask for more documents if needed. In no event will the decision take longer than 15 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the Enrollee believes he/she needs further review of said claim, he/she may contact his/her state insurance regulatory agency if applicable or bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if the Contract is subject to ERISA.

CANCELLATION OF CONTRACT

Delta Dental may cancel the Contract only:

- a) on an anniversary of the Effective Date upon 60 days written notice;
or
- b) if your employer does not pay the monthly premiums upon 31 days written notice; or
- c) if your employer does not provide a list of who is eligible upon 60 days written notice.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Delta Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Forms

Delta Dental will give any Dentist or Enrollee, on request, a standard Claim Form to make claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the Enrollee is a minor) and submitted to Delta Dental.

If the form is not furnished by Delta Dental within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written Notice of Claim/Proof of Loss

Delta Dental must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss should be submitted no later than March 31 immediately following the end of the Calendar Year in which services were incurred.

All written proof of loss must be given to Delta Dental within 12 months of the termination of the Contract.

Time of Payment

Claims payable under this Contract for any loss other than loss for which this Contract provides any periodic payment will be paid within 30 days after written proof loss is received. Delta Dental will notify the Primary Enrollee and his/her dentist of any additional information needed to process the claim within this 30 day period. Delta Dental will process the claim within 15 days of receipt of the additional information. If the requested information is not received within 45 days, the claim will be denied. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly.

To Whom Benefits are Paid

PPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Contract will be made to the Primary Enrollee, unless the Enrollee requests when filing a proof of loss claim that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist will be payable to the Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting him.

Legal Actions

No action at law or in equity will be brought to recover on this Contract before 60 days after written proof of loss has been given in accordance with requirements of this Contract. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

THIS CERTIFICATE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTAL INSURANCE CONTRACT. THE COMPLETE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

